Employee Election for Lost Time Benefits

State Employee Injury Compensation Trust Fund/SEICTF

Submit to SEICTF when the employee will miss more than three (3) days or 24 hours of work.

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ATTENTION EMPLOYEE:

Your options for lost time benefits are:

A) First three days off work due to occupational injury (waiting period). You should:

1) Utilize available annual/sick leave, or
2) Take unpaid days.
3) File with your agency=s payroll department only.

B) After three day waiting period. You should:

1) Take SEICTF benefit of two-thirds pay with no deductions, federal or state taxes, or retirement credit. Accrue leave at 2/3rds of regular leave rate, or
2) Take available annual/sick leave. Regular deductions and RSA contribution continue.
3) FAX this form to SEICTF immediately at (334) 223-6170 or 888-827-6753.

Select the option on this form you wish to use. You may change the option you selected under (B) at the beginning of any regular pay period. This selection cannot be retroactive. **Elections must be made by the employee and received by SEICTF before any compensation benefits are paid.**

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TO BE COMPLETED BY EMPLOYEE:

Employee Name _____ SSN _____

Date of Injury _____

Employing Agency _____

********** Payment Option Selected by Employee: **(A and B must be completed)**

A) 1. Annual/Sick leave for three day waiting period.
2. Leave without pay for three day waiting period.

B) 1. SEICTF Wage Replacement beyond three day waiting period.
2. Annual/Sick leave beyond three day waiting period.

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TO BE COMPLETED BY AGENCY:

1. Gross Salary at Time of Injury $ _____ Semi-monthly $ _____ Hourly Rate
2. **First** three WORKING days or 24 working hours of work missed due to injury?
   (Give exact dates) _____
3. Employee status (check one): Part-Time Full-Time Contract
4. Retirement Plan Info: _____Type (TRS, ERS, Judicial, State Police, etc.)

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TO BE COMPLETED BY SEICTF:

Wage Replacement - Calculated Benefits (Current weekly wage times 2 divided by 3)

RSA Adjusted Amount $ _____ Semi-Monthly _____ Employers %

Two-thirds Amount $ _____ Semi-Monthly _____ Employees %

Approved:

Effective Date:_____ Signature _____ Date: _____

Disapproved:

Effective Date: _____ Signature _____ Date: _____

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EMPLOYEE MUST SIGN PAGE 2

By signing below:

1. I certify that I have read this form and that I have freely chosen the option marked on page 1.

2.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize any physician, health care professional, hospital, or other medical facility to provide my complete health care records to representatives of the State Employee Injury Compensation Trust Fund (SEICTF), and/or its' agents regarding my health and any treatment rendered. I authorize representatives of SEICTF and or its' agents to examine any and all records including but not limited to: all history and physical examinations; progress notes; physicians' notes; lab reports; x-ray, MRI, CT scans, myelograms and all other diagnostic procedure reports; all consultation reports and records, in-patient and out-patient facility records; operative reports; payment records, prescribed medications; and all notes, correspondence and records of any kind.

In addition, I authorize the release of information relating to (1) communicable diseases such as hepatitis and the human immunodeficiency virus (HIV); (2) substance abuse treatment records; and (3) all mental health treatment records.

The purpose for disclosure of these records is to allow SEICTF to evaluate my medical history and injuries in this claim and to administer benefits I may be eligible for under the SEICTF program. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. This Authorization for Release of Health Information is valid for one year from the date the patient signed this release.

I understand that I may revoke this authorization by sending a signed, written notice to SEICTF and to the healthcare provider(s) authorized to disclose my health information pursuant to this document. However, I also understand that any revocation will be effective only to the extent that action has not already been taken in reliance of this authorization.

By refusing to sign or revoking this authorization, I understand that SEICTF will be unable to provide benefits under this program as medical records are required.

Employee Signature	Home Phone & Employee Daytime Number	Date
Supervisor	Supervisor Phone Number	Date